IN THE SUPREME COURT OF THE STATE OF MONTANA
No. DA 09-0682

JEANETTE DIAZ, LEAH HOFFMANN-BERNHARDT, RACHEL LAUDON, individually and on behalf of others similarly situated,

Plaintiffs and Appellants,

v.

BLUE CROSS AND BLUE SHIELD OF MONTANA, NEW WEST HEALTH SERVICES, MONTANA COMPREHENSIVE HEALTH ASSOCIATION, STATE OF MONTANA, AND JOHN DOES 1-100,

Defendants and Appellees.

APPELLEE STATE OF MONTANA'S ANSWER BRIEF

On Appeal from the First Judicial District Court,
Lewis & Clark County, Montana
Cause No. BDV 2008-956
Honorable Jeffrey M. Sherlock

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

Cases

TABLE OF AUTHORITIES - Cont'd

Page

Cases

TABLE OF AUTHORITIES - Cont'd

Page

Statutes

TABLE OF AUTHORITIES - Cont'd

Page

Other Authorities

I. STATEMENT OF ISSUES

The sole issue on appeal is whether the district court abused its discretion in denying Plaintiffs' Motion for Class Certification.

II. STATEMENT OF THE CASE

Plaintiffs, Diaz, Hoffmann-Bernhardt, and Laudon, filed their Complaint on October 23, 2008. The case presents a claim arising out of the handling of health care expenses under separate benefit plans issued by the State of Montana ("The State") and the Montana Comprehensive Health Association ("MCHA"). Defendants, Blue Cross Blue Shield of Montana, Inc. ("BCBS"), and New West Health Services ("New West") are joined primarily as third-party administrators. The Complaint seeks certification of a class arising from benefit plans issued by The State or MCHA. Although none of the Plaintiffs have such a claim, the Complaint seeks certification of a class that would include claims arising under policies issued or sold directly by BCBS or New West, without any connection to The State or MCHA.

The Plaintiffs have very different claims. Diaz brought a claim against The State and BCBS, but not against MCHA or New West. Hoffmann-Bernhardt brought claims against The State and New West, but not against BCBS or MCHA. Finally, Laudon brought claims against

MCHA and BCBS, but not against The State or New West. Although not all enumerated, the Complaint includes the following claims:

(1) the "right to be made whole" as "expressed in Montana cases and §33-30-1102[sic]";

(2) a declaratory judgment, seeking to declare the Defendants had violated the "made whole law of Montana" and to "calculate the amount wrongfully withheld from the individual class members and make payments thereof";

(3) for unjust enrichment; and

(4) for class certification, under Montana Rule of Civil Procedure 23.

Compl., Class Action Req. & Class Action Claims 6, 13 (Oct. 23, 2008).

On March 6, 2009, the Plaintiffs filed a Motion to Amend the Complaint. On March 16, 2009, the Plaintiffs filed a Supplemental Motion to Amend the Complaint. Without waiting for a response from the court on these motions, the Plaintiffs filed their Motion to Certify the Class under Montana Rule of Civil Procedure 23, on March 17, 2009.

The Plaintiffs' Amended Complaint sought to add the following claims to the case:

(1) against The State and BCBS, for bad faith under Montana Code

Annotated § 33-18-201 et seq.;

(2) against The State and BCBS, for breach of contract and violations of Montana Code Annotated §§ 27-1-311-312;

(3) against all Defendants, for deceit, pursuant to Montana Code Annotated § 27-1-712;

(4) against all Defendants, for actual or constructive fraud, pursuant to Montana Code Annotated §§ 28-2-405-406 (2009); and

(5) against all Defendants, that they "acted in concert."

See generally Pls.' Mot. Amend Compl. & Memo. Support. Plaintiffs' attempts to amend the Complaint were opposed by Defendants. Following the filing of Defendants' objections, the district court has not ruled on either Motion to Amend the Complaint, as filed by Plaintiffs.

On June 12, 2009, Plaintiffs filed a motion entitled "Motion for Rule 23 (d) Orders and Partial Summary Judgment." Among other relief requested, each Plaintiff sought an order against the Defendants as follows:

(1) declaring that Defendants violated their obligation to determine whether the Plaintiffs had been made whole;

(2) declaring that each Plaintiff was entitled to partial summary judgment that she was not made whole; and

(3) for an order requiring Defendants to calculate the amount of

benefits they have wrongfully deprived each Plaintiff of under their respective benefit plans.

See Pls.' Br. Support Ct. Ors. Control Proc. Under Rule 23 & Associated Relief 12-18 (June 12, 2009).

On July 13, 2009, The State moved for partial summary judgment on all claims from Plaintiff Laudon, on the basis that Laudon did not assert a claim against The State. The district court has not ruled on this motion. On August 24 -25, 2009, the parties presented evidence to the district court on the Plaintiffs' Motion for Class Certification. The district court entered an order, denying this motion on December 16, 2009. This order denying class certification is the subject of this appeal.

Approximately two weeks later, on December 30, 2009, the district court issued an order approving Laudon's dismissal with prejudice of all claims against BCBS and MCHA. The order did not address any claims Laudon may have against The State and/or Defendant New West, although it appears none were asserted. On that same day, Diaz and Hoffmann-Bernhardt filed a notice of appeal. Laudon did not appeal the denial of the Plaintiffs' class certification motion.

III. STATEMENT OF RELEVANT FACTS

The State is the largest employer in Montana. *See* App. Appellee

State Montana's Ans. Br. ("App.") 1 at 12 (Rptr.'s Transcr. Appeal 162:16-20 (Aug. 24-25, 2009)). The State provides a self-funded employee group benefit plan for its employees. The State's Employee Benefit Plan ("the Plan") was established by the Montana Legislature in 1979. *See* App. 1 at 11 (161:8-11). The State has approximately 32,000 individuals enrolled in its various plans. *See* App. 1 at 14 (184:8-13). The Plan is a self-insured disability plan that provides health care coverage for The State's employees, retired state employees, and their dependents (including the executive branch, legislative branch and judicial branch personnel). *See* App. 2 at 24 (2nd Aff. Connie Welsh ¶ 5 (July 1, 2009)). The Plan is supported by two primary sources of funding:

a) Approximately one-third of the funding comes from contributions paid directly by employees who cover their dependents and by retirees. (Retirees pay 100% of their contributions.); and

b) The remaining two-thirds are derived from the employer contribution, which covers the majority of the cost of the employee-only coverage.

See App. 2 at 24 (¶ 6).

The employer contribution, often referred to as "the State share," is allocated biennially by the Legislature as part of the collective bargaining agreement for employee pay raises and state share contributions, and it is

appropriated in the State pay plan bill (typically known as House Bill 13). *See* App. 2 at 24 (¶ 7). Since 1993, the executive branch has negotiated a pay package that allocates a pool of funds to be set aside in the Governor's budget between what is required to support increased costs under the Plan, with the amount remaining after payment of these health care costs considered for pay increases to employees. *See* App. 2 at 25 (¶ 8).

Historically, the priority for unions and plan members has been maintaining the benefits over and above any increases in pay. *See* App. 2 at 25 (¶ 9). Plan members support the cost of the self-insured pool through payment of their contributions and through the State share. The employment package is divided between direct employee pay and employer contribution to healthcare benefits. *See* App. 2 at 25 (¶ 10). Thus, increased costs in the Plan directly reduce take-home pay available to the employee Plan members. *See* App. 2 at 25 (¶ 11).

The Department of Administration was tasked with operating this plan and was required to offer group benefits related to medical, hospitalization, life, and disability. *See* App. 1 at 11-12 (161:17-162:8). The State offers four distinct medical plans. There is an indemnity plan, and three different medical-managed care plans that provide the opportunity for members to use benefits through three different third-party administrators. The

administrators are BCBS, New West, and Allegiance Benefit Management Plan, in conjunction with Peak Health Plan. *See* App. 1 at 12-13 (162:12-163:3). The State also offers benefits for dental and long term disability. *See* App. 1 at 12 (162:9-15). These plans are available to The State's employees and their dependents. The benefit plans from The State are also available to retirees and their dependents. *See* App. 1 at 13 (163:4-8).

The State's Plan was established under Title 2, Section 18, of the Montana Code Annotated. It is exempt from the rigors of insurance code under Title 33, as it is an alternative to conventional insurance. *See* Mont. Code Ann. §§ 2-18-812 and 33-1-103(7) (2007).[1] The Plan's purpose is to "establish a program under which the state may provide state employees with adequate group hospitalization, health, medical, disability, life, and other related group benefits in an efficient manner and at an affordable cost." *See* Mont. Code Ann. § 2-18-808 (2009).

Since at least 2003, the Plan has contained the following provision to addresses the coordination of benefits in conjunction with payments from third-parties.

The following services and expenses are not covered:

---

[1] Section 33-1-103(7) was modified slightly by the 2009 legislature and became § 33-1-102(7), but the 2007 statute should apply to Plaintiffs' claims.

* * *

> 5. Expenses that a member is entitled to have covered, or that are paid under an automobile insurance policy, a premise liability policy, or other liability insurance policy. This includes but is not limited to, a homeowner's policy or business liability policy, or expenses that a member would be entitled to have covered under such policies if not covered by the State Plan.

See App. 2 at 25 (¶ 12).

From approximately 2000 until sometime in 2006, the State's Health Care and Benefits Division had a process in place upon receiving a claim from a member injured by a third party. *See* App. 3 at 28 (Aff. Connie Welsh ¶ 3 (Apr. 7, 2009)). If the member had an attorney, the Division would contact the attorney and discuss two issues. The first was to explain the coordination of benefits provision in the Plan. *See* App. 3 at 28 (¶ 3). The provision applied when either the third-party automobile insurance or premises liability insurance paid a claimant's medical expense.

The second issue discussed was whether the claimant had been made whole by the third-party. *See* App. 3 at 28 (¶ 3). If the records and information showed that claimant had not been made whole, the State would pay the claimant in exchange for a release of claims. If the claimant had been made whole, the claimant would be asked to sign a release. Typically, a fair resolution was reached with claimant's counsel. *See* App. 3 at 28

(¶ 3). This practice continued until sometime in 2006, when lack of staff funding required changes and this practice was discontinued. *See* App. 3 at 28 (¶ 4).

Unlike The State's plans, the MCHA does not provide benefits for groups of employees. It is a statutory public-interest nonprofit association created for the purpose of making disability health plans available to eligible persons who are unable to obtain disability insurance in the marketplace. *See* App. 4 at 34 (MCHA's Responses Pls.' 1st Discovery Reqs., Response Discovery Req. No. 1 (Apr. 29, 2009) (citing En. 1985, Mont. Laws. Ch. 595). The premium allowed to be charged to MCHA members is limited by statute. *See* Mont. Code Ann. § 33-22-1512 (2009). To augment insufficient premiums, the MCHA is permitted to accept funding from the federal government, private foundations, and other sources. *See* Mont. Code Ann. § 33-22-1513(8).

The MCHA offers three health care plans:

(1) the association traditional plan (medically eligible);

(2) the association portability plan (portability eligible); and

(3) the premium assistance plan (medically and income eligible).

See App. 4 at 34. The definition for persons eligible to obtain health care benefits from MCHA is set forth in Montana Code Annotated § 33-22-

1501(7). The MCHA provides pooled health benefits considered as a "last resort" to those unable to get coverage elsewhere. *See* App. 5 at 42 (MCHA's Response Pls.' Mot. Rule 23(d) Ors. & P.S.J. (July 6, 2009)); Mont. Code Ann. § 33-22-1503(1) (2009). Unlike the State's Plan, which is exempt from Title 33, the MCHA plan has been approved by the Montana State Auditor. *See* App. 4 at 35.

BCBS is one of the administrators for The State's employee benefit plan. BCBS administers the plan and is reimbursed by The State for payments made arising from claims under the plans. *See* App. 1 at 6-7 (106:19-107:4). The funds for these plans come from The State, as they reimburse BCBS for any payments. BCBS is also the lead carrier for the MCHA health care plans, acting as the third-party administrator. *See* Mont. Code Ann. § 33-22-1501(12) (2009). In addition, BCBS also sells health care coverage in policies it pays on its own. These plans are different as BCBS assumes the risk, a premium is charged based on the risk and BCBS underwrites any loss for claims on its fully insured plans. *See* App. 1 at 7-8 (107:17-108:13).

BCBS is paid a flat fee per member for administering The State's benefit plan. *See* App. 1 at 5-6 (105:21-106:9). BCBS does not provide underwriting for The State's plans, as it is The State's money that ultimately

pays for these medical claims. *See* App. 1 at 7 (107:2-10). The vast majority of claims are submitted electronically to BCBS, so they require notification to know if the injuries were related to an accident. *See* App. 1 at 9-10 (111:16-112:25).

The class as defined by Plaintiffs would include policies sold directly by BCBS. In its policies, BCBS uses the following "exclusions and limitations":

> The exclusions at issue provide that BCBS will not pay health care benefits to its beneficiaries for:
>
> Services, supplies, and medications provided to treat any injury to the extent the member receives, or would be entitled to receive where liability is reasonably clear, benefits under an automobile insurance policy. Such benefits received by the member shall be used first to satisfy any remaining coinsurance, copayments and deductibles related to the injury for which claims are submitted to the plan. The injury related claims must be submitted to the plan to apply any applicable credit to coinsurance, copayments and/or deductibles.

Blue Cross & Blue Shield of Mont., Inc. v. Mont. State Auditor, 2009 MT 318, ¶ 8, 352 Mont. 423, 218 P.3d 474 (including a similar exclusion for payments from premises liability coverage).

New West is one of the third-party administrators for The State's health benefit plans, processing claims on behalf of The State. *See* App. 1 at 17-18 (235:25-236:11). New West receives claims directly from health care

providers and claims are reviewed for coverage, legitimacy and then paid or denied. *See* App. 1 at 15-16 (232:17-233:9). New West does not collect premiums; rather, it receives a flat fee per month that remains unaffected whether a claim is accepted or denied. *See* App. 1 at 18 (236:15-24).

With regard to the named Plaintiffs and their various claims, Diaz was injured in an auto accident in December 2006. *See* Compl. 5. As an employee of The State, Diaz was a member of a self-funded employee benefit plan which provides reimbursement for certain medical expenses. *See* App. 6 at 48 (The State's Responses Pls.' 1st Discovery Reqs., Discovery Req. No. 15(A) (May 4, 2009)). Diaz claims that The State wrongfully denied payment for medical costs and/or failed to reimburse her for medical costs arising from an auto accident. *See* Compl. 5-6. BCBS was the third-party administrator for Diaz' employee benefit plan. *See* App. 7 at 52-54 (BCBS' Ans. Pls.' 1st Discovery Reqs., Discovery Req. No. 15 (Apr. 8, 2009)).

Hoffmann-Bernhardt was in an auto accident in September 2005. *See* Compl. 7. New West and BCBS were the third-party administrators for her state employee benefit plan. *See* Compl. 7. For her medical claims, New West first received notice that there was a third-party paying the medical claims when the funds were returned by a healthcare provider. *See* App. 1 at

19-20 (239:1-240:15). There was nothing in the New West file for Hoffmann-Bernhardt which would have affected subsequent claims after that date and, thus, New West never denied a claim submitted on behalf of Hoffmann-Bernhardt related to her auto accident. *See* App. 1 at 21 (241:3-17). Likewise, it never solicited any refunds or reimbursements. Plaintiff Hoffmann-Bernhardt claims The State, New West, and BCBS withheld medical payments arising from her accident which had been paid by a third party. Hoffmann-Bernhardt claims the Defendants' conduct was unlawful as she had not been made whole. *See* Compl. 7-8.

Laudon was in auto accident in November 2006. *See* Compl. 8. She was a member of a benefit plan with MCHA. *See* App. 4 at 37-38 (Discovery Req. No. 15). Laudon was <u>not</u> a member of The State's Plan. *See* App. 3 at 28 (¶ 2). BCBS was the third-party administrator for the MCHA benefit plan. *See* App. 8 at 59-60 (Laudon's Ans. The State's 1st Discovery Reqs., Interrog. No. 3 (Mar. 11, 2009)). Laudon claims that MCHA and BCBS improperly "accepted return of money from health care providers" who had been paid by a third party. *See* Compl. 9.

There is no dispute that the actual medical bills for all three named Plaintiffs were paid in full by the third-party insurers, State Farm and Met Life. *See* Or. Re: Class Action Req. 5 (Dec. 16, 2009) (hereinafter

"Certification Or."). Diaz' damages exceeded State Farm's policy limits, but Hoffmann-Bernhardt settled her claim for less than policy limits. *See* Certification Or. 7. At the time when the district court ruled on the class action request, Laudon still had not settled her claim against the third-party insurer. *See* App. 8 at 61-62 (Interrog. No. 8); *see also* Certification Or. 5.

Although the proposed class definition had evolved throughout the litigation, Plaintiffs claim the appropriate definition includes current and former State employees covered by The State employee benefit plan, or MCHA plan participants, who:

> 1. were injured in automobile accidents caused by third parties whose auto liability insurer paid medical bills in accordance with *Ridley*.
>
> 2. are subject to the above-referenced exclusions from coverage;
>
> 3. were arguably not made whole by the tortfeasor, the tortfeasor's insurer, or their own automobile insurer; and
>
> 4. claim entitlement to the amount of medical benefits which would have been paid under the State or MCHS's schedule of benefits but for payment by the tortfeasor's auto liability insurer, or some other insurer.

See Certification Or. 6. This is the definition of the class the district court rejected. Notably, the Plaintiffs' brief to this Court does not propose another. *See* Appellant's Opening Br. 28-29 (Apr. 12, 2010). Although

Laudon may no longer be part of this case, she was at the time when the district court ruled on the Plaintiffs' Motion for Class Certification. Thus, any appellate review must consider Laudon as part of the circumstances in the case because her claims were still viable at the time of the underlying district court decision.

IV. STATEMENT OF STANDARD OF REVIEW FOR EACH ISSUE RAISED

The district court has the "broadest discretion" in deciding whether to certify a class. *McDonald v. Wash.*, 261 Mont. 392, 399-400, 862 P.2d 1150, 1154 (1993). A district court's ruling on class certification will not be disturbed unless there was an abuse of discretion. *Ferguson v. Safeco Ins. Co. of Am.*, 2008 MT 109, ¶ 10, 342 Mont. 380, 180 P.3d 1164. In class action cases, this Court has stated that "[t]he judgment of the trial court should be accorded the greatest respect because it is in the best position to consider the most fair and efficient procedure for conducting any given litigation." *Sieglock v. Burlington N. Santa Fe Ry.*, 2003 MT 355, ¶ 8, 319 Mont. 8, 81 P.3d 495 (citing *McDonald*, 862 P.2d at 1154).

V. ARGUMENT

A. Short Summary of Argument

With regard to the class action request, this case was procedurally

defective from its inception. As designed and plead by Plaintiffs, it is not suitable for a class action. The three named Plaintiffs brought claims under different health benefit plans. These health benefit plans arise in very different contexts and under different legal authority. Totally different laws apply to the respective plans. Even though the individual Plaintiffs did not have claims against some of the named Defendants, they were designated in a single lawsuit as representatives for the entire class, part of which they were not even a member. The class as defined also includes claims against BCBS/New West for health plans sold directly to consumers; yet, none of the Plaintiffs are in such a position so as to represent this part of the class. The Plaintiffs also each had their own unique factual circumstance with regard to the medical claims made, and payments sought, which could have legal implications on potential relief. For certain named Plaintiffs, payments were made to the healthcare provider, but thereafter it was returned because payment was received from another source. For other Plaintiffs, the medical claims were not submitted until years after their treatment, well after the claim filing period had expired.

The class was also problematic as it was defined to include members with whom The State had previously settled. In addition, the class was poorly defined, a basic requirement for the identification of any certified

class. The structure of the class as proposed also created logistical problems in identifying class members. One example of this is when medical providers receive *Ridley* payments, they will not double bill the respective health benefit plan. In this situation, the benefit plan does not have notice that an expense was incurred, as no claim was ever submitted. Finally, the nature of the relief sought and the structure of the claims as alleged mandate a series of mini-trials prior to any final legal determination.

B. Full Argument

1. The District Court Ruling

The district court heard evidence and argument on the class certification issues on August 24-25, 2009. The district court issued its decision, denying the Plaintiff's Motion for Class Certification on December 16, 2009. Even if the putative class shared some common questions of law, the court found that certification was not appropriate if the ability of each class member to recover damages required an individualized review of the facts. *See* Certification Or. 14. The court recognized that all of the medical bills of the three named Plaintiffs had been paid in full. As a result, The State and MCHA had been reimbursed for any duplicate payments. *See* Certification Or. 13. The court found that the issue of whether an injured claimant has been made whole is a question of fact that is dependent upon

the level of recovery and the extent of her compensation. *See* Certification Or. 7. Furthermore, the Court found that the variety of claims as asserted by Plaintiffs for bad faith, deceit, constructive fraud, compensatory and punitive damages would require individualized review of the related facts for each claim.

The district court also noted that a different analysis of the subrogation issues applied to legislatively promulgated health insurance plans. *See* Certification Or. 15. In addition to arising outside of Title 33, the district court found these plans were unlike traditional insurance because these health benefit plans do not charge a premium, do not provide mandatory coverage, and, thus, are more akin to subsidized medical coverage. *See* Certification Or. 15. Under the circumstances, some payments sought by Plaintiffs in excess of medical coverage could result in a double payment to class members, in violation of Montana law. *See* Certification Or. 15.

Finally, the district court found that the Plaintiffs failed to narrowly define their class, as it included The State's Plan which was not governed by Title 33, an insurer of last resort in MCHA, and auto insurers who were legally required to pay the claims at issue. *See* Certification Or.17. Thus, issues of individualized proof would predominate over any common issues.

See Certification Or. 17-18. Accordingly, the district court denied Plaintiff's Motion for Class Certification.

2. Rule 23 Considerations

The propriety of a class action is determined under Montana Rule of Civil Procedure 23. Because the Montana and federal rules on class certification are essentially identical, this Court recognizes that the body of case law interpreting the federal rule is instructive. *McDonald*, 862 P.2d at 1154. The threshold inquiry into whether a class action is proper requires analysis of four prerequisites of Rule 23(a): (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. *Sieglock*, ¶¶ 10-12. A court "must engage in a rigorous analysis" to satisfy these prerequisites and have sufficient information to form a reasonable judgment on each requirement for certification. *Burton v. Mt. W. Farm Bureau Mut. Ins. Co.*, 214 F.R.D. 598, 608 (D. Mont. 2003); *Blackie v. Barrack*, 524 F.2d 891, 901 (9th Cir. 1975). The plaintiff bears the burden of showing that each of the elements of Rule 23 has been met. *Alexander v. JBC Leg. Group, P.C.*, 237 F.R.D. 628, 630 (D. Mont. 2006). Failure of any one of these prerequisites is fatal to the certification of the entire class as proposed. *Murer v. Mont. State Comp. Mut. Ins. Fund*, 257 Mont. 434, 849 P.2d 1036 (1993); *Rutledge v. Elec. Hose & Rubber Co.*, 511 F.2d 668, 673 (9th Cir.

1975).

3. Definition of the Class

Prior to considering the specific criteria set forth in Rule 23(a), a court must first find that the class is precisely defined and that the identified class representatives are members of the class. *Polich v. Burlington N., Inc.*, 116 F.R.D. 258, 261 (D. Mont. 1987) (*citing in part Roman v. ESB, Inc.*, 550 F.2d 1343, 1348 (4th Cir. 1976)); *see also Bentley v. Honeywell Intl., Inc.*, 223 F.R.D. 471, 477 (S.D. Ohio 2004) ("Before delving into the 'rigorous analysis' required by Rule 23, a court first should consider whether a precisely defined class exists and whether the named plaintiffs are members of the proposed class."); *Robinson v. Gillespie*, 219 F.R.D. 179, 183 (D. Kan. 2003) (the court begins with the proposed definition of the class because absent a cognizable class, the Rule 23 requirements are irrelevant); *Thomas & Thomas Rodmakers, Inc. v. Newport Adhesives & Composites, Inc.*, 209 F.R.D. 159, 163 (C.D. Cal. 2002) (the Rule 23 factors are not considered until after ascertainable and identifiable class has been defined). Unless there is an unambiguous recitation of common facts or law defining a clearly ascertainable class that does not include dissimilarly situated individuals, certification is not proper. *Sieglock*, ¶¶ 10-11.

In determining whether a class is adequately defined, courts consider

whether the proposed definition identifies with specificity "a particular group that was harmed during a particular time frame, in a particular location, in a particular way" and "facilitat[es] a court's ability to ascertain its membership in some objective manner." *Bentley*, 223 F.R.D. at 477. Courts have declined to certify a class where the proposed definition would not enable identification of class members short of individualized fact-finding. *Crosby v. Soc. Sec. Admin.*, 796 F.2d 576, 580 (1st Cir. 1986); *Noble v. 93 U. Place Corp.*, 224 F.R.D. 330, 338 (S.D.N.Y. 2004) (class definition is rejected if mini-hearing on merits of each plaintiff's case will be necessary to ascertain their class membership). Simply put,

> [a] court should deny class certification where the class definitions are overly broad, amorphous, and vague, or where the number of individualized determinations required to determine class membership becomes too administratively difficult.

Perez v. Metabolife Intl., Inc., 218 F.R.D. 262, 269 (S.D. Fla. 2003).

The class sought to be certified by Plaintiffs has been amorphous and evolving throughout this litigation. *Compare* Compl. 10 *with* App. 9 at 66-67 (Diaz. Ans. The State's 1st Discovery Reqs., Interrog. No. 4 (Mar. 10, 2009)). For its definition of the class, Plaintiffs' Motion for Certification of Class and Brief in Support refers back to the Complaint. *See* Pls.' Mot. Certify Class & Memo. Support Class Certification (Mar. 16, 2009). In the

Complaint, the Plaintiffs define the class as those with the following characteristics in common:

A. They are all insured under health insurance plans and policies administered or operated by defendants.

B. They have been injured through the legal fault of persons, which have legal obligations to compensate them for all damages sustained.

C. They have not been made whole for their damages.

D. In violation of Montana law, the defendants have programmatically failed to pay benefits for their medical cost even though they have not been made whole.

See Compl. 10.

At the evidentiary hearing, the Plaintiffs proposed a revised definition, identifying the class as having the following characteristics:

A. Insured by defendants;

B. Third parties responsible for injuries;

C. Defendants' reduced benefits to third parties; and

D. (optional) Defendants did not first determine if insured was made whole.

See App. 10 at 69 (Hrg. Exs., Slide No. 16 (Aug. 24-25, 2009)); *see also* App. 1 at 4 (35:17-20).

A review of either definition reveals that the proposed class is vague

and not clearly defined. Among other problems, the Plaintiffs' proposed class definition:

A. arose under different health plans, applying different laws and different plan provisions;

B. included individuals who purchased health coverage directly from BCBS and/or New West, without any connection to The State and/or MCHA;

C. would have included individuals whose health benefit plan was with an employer other than The State, but was still administered by BCBS or New West;

D. included claims for which the individually named Plaintiffs were not a member of the class as defined;

E. failed to limit the class to only those who had submitted the medical bills for payment in a timely manner, thus including class members whose rights to recover were time barred;

F. failed to limit the class to require that the medical costs would have otherwise been covered under the health benefit plan;

G. included members who had released all claims against a defendant as part of a compromised settlement;

H. included situations where the health plan actually made

payment and was later returned by the provider, as well as where claims were never submitted, or were submitted and denied because of a coordination of benefits with third-party payers; and

I. failed to define any historical period of time for when the claims must have arisen or been submitted.

In sum, the various definitions as proposed are vague and unworkable from a practical standpoint. The class as proposed would include an enormous variety of claims and claimants, many of whom would have no representative as a named Plaintiff. The class as defined would include individuals with settled claims, claims were never submitted, and claims that are time barred. Furthermore, the class is so disperse that entirely different laws would apply, with those under The State's Plan applying considerations under Title 2, those under the MCHA plan applying another law, and, finally, with those members who had purchased plans directly from BCBS or New West presumably applying Title 33.

One of the primary purposes of certifying any class arises from practical considerations of judicial efficiency as compared with litigating separate cases. *See e.g. McDonald*, 862 P.2d at 1158. Yet, any such benefit is lost if the work involved in identifying who is in the class exceeds any benefit, or the class includes participants who by definition have no claim

whatsoever. The Plaintiffs' proposed class would not streamline the litigation. On the contrary, it would complicate and bog the litigation down with time-consuming and unnecessary questions arising from a lack of any kind of cohesiveness among the class members, the different nature of their claims, and other procedural matters. Without a specific definition for the class that can provide practical guidance to identify the class and streamline the proposed litigation, the proposal to certify a class in this case is untenable and should be rejected.

4. Plaintiffs Must Be Class Members

Rule 23 provides that one or more "members of a class" may file suit. *See* Mont. R. Civ. P. 23(a); *see also Murer*, 849 P.2d at 1038 (a class member can only represent claims of which they are a member). Montana jurisprudence on this issue is in accord with overwhelming authority arising under the identical federal rule holding that a plaintiff cannot represent a class of which she is not a part. *Bailey v. Patterson*, 369 U.S. 31, 32-33 (1962); *O'Shea v. Littleton*, 414 U.S. 488 (1974); *La Mar v. H & B Novelty & Loan Co.*, 489 F.2d 461, 465 (9th Cir. 1973) (it is obvious that typicality is lacking when a representative plaintiff never had a claim against a defendant); *Gen. Tel. Co. of S.W. v. Falcon*, 457 U.S. 147, 156 (1982) (citation omitted) (a plaintiff in a class action "must be part of the class and

'possess the same interest and suffer the same injury' as the class members").

In the present matter, this fundamental requirement is not met. As set forth above, Diaz was an employee covered under The State's Plan, administered by BCBS. Hoffmann-Bernhardt was an employee covered by The State's Plan, administered by New West and BCBS. Finally, Laudon was a member of the MCHA benefit plan, administered by BCBS. As alleged, Diaz would be a class representative for claims against New West and MCHA, but she has claims against neither. Hoffmann-Bernhardt would be a class representative for claims against MCHA, but she has no claim against MCHA. Laudon has claims against BCBS and The State. However, as a Plaintiff she is a class representative for members who have claims against The State and New West, but she has claims against neither. Thus, this is in violation of the general rule that a plaintiff must be a member of any class that he/she represents.

Furthermore, the class as defined would include claims arising against BCBS and/or New West for health benefit polices it sold directly to consumers. *See* Compl. 10; App. 10 at 69; App. 1 at 4 (35:17-20). Yet, there is no named Plaintiff who purchased a health benefit policy directly from BCBS or New West. As set forth in the factual section above, Diaz

and Hoffmann-Bernhardt were members of The State's Plan. Laudon had benefits under the MCHA plan. Thus, the class as defined and proposed by Plaintiffs included an entire section of unique claims for which there was no named class representative.

C. Numerosity, Commonality, Typicality and Representation

If this Court finds the Plaintiffs' proposed class definition is precisely defined and the Plaintiffs are members of the class, it must then turn to the requirements of Rule 23: (1) numerosity; (2) commonality; (3) typicality; and (4) adequacy of representation. *Sieglock*, ¶¶ 10-12. The party seeking certification has the burden to prove the proposed class meets all the requirements of Rule 23 of the Montana Rules of Civil Procedure. *Sieglock*, ¶¶ 5-10.

1. Numerosity

The first element requires that the class be so numerous that joinder of all members is impracticable. *See* Mont. R. Civ. P. 23(a)(1). Mere speculation as to satisfaction of the numerosity requirement is not sufficient; rather, a plaintiff must present some evidence or a reasonable estimate of the number of members in the class. *Polich*, 116 F.R.D. at 261. At the district court, the Plaintiffs simply alleged the number will be "in the hundreds." *See* Pls.' Memo. Support Class Certification 10. Without any authority,

Plaintiffs argue on appeal that because the district court "did not challenge" their position on numerosity, they need not address it. *See* Appellants' Br. 20-21. Because numerosity is one of the required elements under Rule 23 for any class, the Plaintiffs cannot skate by without evidentiary support. Although Plaintiffs refer in other portions of their brief to evidence in the *Neary* case on the number of claimants, they proffer no evidence whatsoever from the record in this case. *See* Appellants' Br. 20-21. With no affidavit for consideration or other support submitted as part of the district court proceedings on the motion, the Plaintiffs' mere assertion that the numerosity requirement is satisfied is insufficient. *Polich*, 116 F.R.D. at 261.

2. Commonality

The commonality element requires that all members of a proposed class should share in common questions of law or fact. *See* Mont. R. Civ. P. 23; *Sieglock*, ¶¶ 10-11. The requirements of commonality are disjunctive. Yet, the nature of the Plaintiffs' claims is directly relevant in determining whether the matters in controversy are individual or suitable as a class action. *Sieglock*, ¶¶ 10-11 (citing *Polich*, 116 F.R.D. at 261). To be certified, Plaintiffs must prove a common nucleus of operative facts. *Ferguson*, ¶ 26.

Here, Plaintiffs' proposed class has neither fact nor law in common.

When looking at putative class members, nearly every ingredient which one might identify as significant to these claims is different. Just to name a few of the differences: (a) differences in the coordination of benefit provisions in the various health plans at issue; (b) differences in whether the claim was paid and returned, withheld, or whether they were even submitted in a timely manner; (c) differences in whether the plan was provided as part of employment, provided under the statutory pool of the MCHA, or purchased directly from BCBS/New West; and (d) differences in the laws which apply (i.e., Title 2, Title 33, and/or the made whole doctrine). All of these basic elements are different when looking at the proposed class.

To elaborate, some plans at issue in the proposed class are provided as part of employment with The State, pursuant to Title 2, Chapter 18. The State's Plans are exempt from Title 33. *See* Mont. Code Ann. § 33-1-103(7) (2007). Whereas, the MCHA plans at issue are provided pursuant to Title 33, Chapter 22. Similarly, policies purchased directly from BCBS and provided by a company to its employees would be included in the defined class. Yet, such policies would be subject to federal laws under ERISA, whereas ERISA does not apply to The State's Plan or the MCHA plans. Policies sold directly by BCBS to individuals would presumably be subject only to Title 33 analysis. The application of the "made whole doctrine" will

depend upon the nature of the underlying program and the statutory authority for the health benefit plan. *Thayer v. Uninsured Employers' Fund*, 1999 MT 304, ¶¶ 20-24, 297 Mont. 179, 991 P.2d 447. The exclusions in the health plans are also different. Thus, some completely different laws and analyses will apply to these claims.

Claims against The State will require specific review to determine which of the claims from putative class members have been settled, as this was the practice of The State for a period of years. There are also factual differences as to whether a policy is provided to an employee free of charge or whether a premium is paid for the benefit. This may also have an effect on whether the made whole doctrine applies to the analysis. Thus, the common nucleus of operative facts and law for the proposed class is not present.

3. Typicality

The third element requires that the claims of the representative parties are typical of the claims of the class. *See* Mont. R. Civ. P. 23(a)(3). The commonality and typicality requirements tend to merge, as both serve as guideposts for determining whether the particular circumstance maintenance of a class is economical and whether the Plaintiffs' claims are so interrelated that the interests of the class members will be adequately and fairly

represented in their absence. *Gen. Tel. Co. of S.W.*, 457 U.S. at 158 n. 13.

As noted, plaintiffs are not entitled to bring a class action against a defendant with whom they have had no dealings. *Murer*, 849 P.2d at 1038 (*citing La Mar*, 489 F.2d 461). Another means of analyzing this situation is to recognize that unless a named plaintiff has a claim against each defendant, that plaintiff lacks standing to proceed. *Easter v. Am. W. Fin.*, 381 F.3d 948, 962 (9th Cir. 2004) (borrowers who sued financial institutions did not have standing to sue defendants who never held any loans of named plaintiff); *Thompson v. Bd. of Educ. of Romeo Community Schs.*, 709 F.2d 1200, 1204-1205 (6th Cir. 1983). In the words of the U.S. Supreme Court, a plaintiff "cannot represent a class of whom they are not a part." *Bailey*, 369 U.S. at 33.[2]

Plaintiffs argue their representative claims are "squarely aligned in interest" with the class. *See* Appellants' Br. 23. Yet, the present case was structured and the class defined in such a manner that there is enormous divergence in the various claims and putative class members, as compared with the claims of the identified Plaintiffs. The Plaintiffs choose an inordinately broad target – trying to sue four different Defendants under at

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[2] Although *Bailey* was decided under the original Rule 23, it has been relied upon by the U.S. Supreme Court for this principle since the 1966 revision to the rule. *See O'Shea*, 414 U.S. at 494.

least four distinct types of health plans, with separate laws governing each. As a result – little is "typical" in the case where most everything is unique, separate and distinct.

The Plaintiffs may argue that an exception applies to the general rule where all defendants are "juridically related in a manner that suggests a single resolution of the dispute will be expeditious," citing the *Murer* decision, which discussed this exception. *Murer*, 849 P.2d at 1039. However, this exception does not apply in the present case. To constitute a "juridical relationship," the connective link "must go beyond mere commonality or parallel actions between defendants." In *Murer*, the Court noted one possible such link where all defendants are "related instrumentalities of a single state, such as various law enforcement agencies." *Murer*, 849 P.2d at 1039. However, the Court found that this was not present because, even though one defendant was an instrumentality of the State, the others were not. *Murer*, 849 P.2d at 1039.

In the present case, BCBS and New West are not instrumentalities of the State. In addition, The State's Plans are controlled by Title 2 and exempt from Title 33; whereas, MCHA is created under Title 33, Part 22. Hence, this exception does not apply. Just as in *Murer*, because the named Plaintiffs do not have claims against all Defendants, the class action is fatally flawed

and should be denied. There can be no typicality in a class so broadly defined, with claims under multiple plans, against multiple defendants, applying differing laws.

4. Adequacy of Representation

The fourth requirement of Rule 23 permits certification only if the representative parties will fairly and adequately protect the interests of the class. *See* Mont. R. Civ. P. 23(a)(4). Although Appellants' Brief discusses the attorneys' representation of the class, this fourth element also compares the relationship between the interests of the named class representatives and the interests of the other class members. *Neff v. VIA Metro. Transit Auth.*, 179 F.R.D. 185 (W.D. Tex. 1998). A primary problem arises for Plaintiffs in the adequacy of representation because: (a) named plaintiffs have no claims against some defendants; and (b) an entire spectrum of the class is unrepresented in the case.

The issue involved in class action cases with multiple defendants was discussed at length by the U.S. Court of Appeals for the Ninth Circuit in the *La Mar* decision. The appellate court in *La Mar* identified the issue as whether a plaintiff can institute a class action against a defendant and a group of unrelated defendants because the unrelated defendants have engaged in similar conduct as that of the defendant with whom the plaintiff

had direct dealings. *La Mar*, 489 F.2d at 462. In such situations, there are problems of standing, because the plaintiff has no claims against the other defendants. *La Mar*, 489 F.2d at 464. Ultimately, this factual situation results in deficiencies in the Rule 23 prerequisites for typicality and adequacy of representation. *La Mar*, 489 F.2d at 465-466. The requirement for typicality "obviously" cannot be met when the representative never had a claim of any type against a named defendant. *La Mar*, 489 F.2d at 465.

Likewise, a plaintiff who has no cause of action against a named defendant cannot adequately represent the members of that class. This is true even though the plaintiff may have suffered an identical injury at the hands of a party other than the defendant and even though his attorney is excellent in every material respect. *La Mar*, 489 F.2d at 466. Because of these concerns, the court in *La Mar* denied class certification. *La Mar*, 489 F.2d at 466.

In the present case, Diaz is identified as a class representative for putative class members with claims against MCHA and New West; yet, Diaz has no claims against these Defendants. Hoffmann-Bernhardt is a named class representative for class members against MCHA; yet, she had no dealings with MCHA. Finally, the Plaintiffs' Motion for Class Certification names Laudon as a representative for claims against The State and New

West; but yet, Laudon has no claims against these Defendants. This problem in representation is exacerbated in the present case because the class as proposed includes claims against BCBS and New West for health plans sold directly to consumers. However, none of the named Plaintiffs are members of this class and, thus, the representation here is completely lacking.

Because the named Plaintiffs do not all have dealings with each Defendant, they cannot adequately represent a member of the class against a Defendant for whom they have no claim. This is axiomatic. Similarly, these named Plaintiffs cannot begin to represent a class which includes claimants who purchased health coverage directly from BCBS or New West, as none of these Plaintiffs' damages arise from such a transaction or policy. Because adequate representation is lacking under Rule 23, class certification was properly denied by the district court.

D. Rule 23(b) and the *Ferguson* Case

If a class as defined satisfies all of the foregoing requirements of Rule 23(a)(1)-(4) (and this class does not), a class must still satisfy section (b) of Rule 23. Subpart (b) of this rule provides three ways it can be satisfied. Relying on a claim for injunctive relief, Plaintiffs in the present case seek certification under Rule 23(b)(2) and also under Rule 23(b)(3). *See*

Appellants' Br. 20-27. Montana Rule of Civil Procedure 23(b) provides:

> **Class actions maintainable.** An action may be maintained as a class action if the prerequisites of subdivision (a) are satisfied, and in addition: (1) the prosecution of separate actions by or against individual members of the class would create a risk of
>
> (A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or
>
> (B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or
>
> (2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or
>
> (3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include: (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions; (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class; (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; (D) the difficulties likely to be encountered in the management of a class action.

To support their argument on Rule 23(b), Plaintiffs rely on *Ferguson*, which Plaintiffs argue governs this case. Indeed, much of Plaintiffs' entire argument to this Court is premised on claimed similarities to *Ferguson.* Yet, the *Ferguson* decision is readily distinguishable from the facts of the present case.

Indeed, *Ferguson* was a totally different case. In *Ferguson*, a single plaintiff who had an insurance policy sued a single defendant, Safeco. *Ferguson*, ¶ 3. The class was readily identifiable from a simple class definition. The class as defined in *Ferguson* is summarized below:

> persons, including natural individuals and business entities:
>
> a. Who were insured under an auto insurance policy issued by Safeco Insurance of America;
>
> b. Who, as a result of an auto accident, suffered expenses covered by such policy;
>
> c. Who received payments under the coverages of such policy;
>
> d. With respect to whom Safeco recovered from a third-party subrogation for some/all of such payments;
>
> e. Whose claim arose not more than eight years ago.

Ferguson, ¶ 7. For this class, identification of the class members was quite simple. Likewise, a single set of laws under Title 33 applied to the policy at issue.

Unlike *Ferguson*, the present case does not have a single policy, a single Defendant or a single Plaintiff. This case has three Plaintiffs who each have a benefit plan with a different Defendant, with the plans administered by a different Defendant, and the plans statutorily authorized by different laws. Also included in the Plaintiffs' putative class are claims for which there is no representative. This is in marked contrast to the class as proposed by Plaintiffs in their Complaint, whom they describe as having the following characteristics in common:

> 1. They are all insured under health insurance plans and policies administered or operated by defendants.
>
> 2. They have been injured through the legal fault of persons, which have legal obligations to compensate them for all damages sustained.
>
> 3. They have not been made whole for their damages.
>
> 4. In violation of Montana law, the Defendants have programmatically failed to pay benefits for their medical cost even though they have not been made whole.

See Compl. 10 (emphasis added).

By the Plaintiffs' own definition, it would include plans from The State, plans of MCHA, plans sold by BCBS or New West. As we have seen, each of these scenarios would require application of a different set of laws. The Plaintiffs' definition, by its own terms, would require a made whole

analysis to determine who is in the class. Whereas, in *Ferguson*, the class included anyone for whom Safeco had recovered in a subrogation action – a very straightforward identification. In the present matter, there was no subrogation action. As noted in the present case, many medical claims were not even billed to Defendants. Other claims were withheld, while still others were paid but then reimbursed. The problem with the proposed class is compounded exponentially because of the multiple claims asserted against multiple defendants. In summary, the clear and distinct class of a single claimant suing under a single policy against a single defendant in *Ferguson* stands in marked contrast to the proposed class, which would be unmanageable, unwieldy, and would present a struggle to identify its members.

The damages sought in the present matter are also distinguishable. In addition to injunctive relief, Plaintiffs seek damages. In their prayer for relief, Plaintiffs seek an injunction to require Defendants to determine the amount of benefits they have withheld and for an order requiring the Defendants to "immediately pay [Plaintiffs] the medical bills incurred" or, in the alternative, after the calculation, the Defendants should be required to pay the Plaintiffs an equal amount. *See* Compl. 15.

Although a class action under Rule 23(b)(2) is primarily for injunctive

relief, it may seek damages, provided they are incidental. *Burton*, 214 F.R.D. 598. The U.S. District Court for the District of Montana in *Burton* recognized that where the damages are merely couched in the form of injunctive relief seeking "an order compelling payment of benefits," this is "nothing more than a request for money damages for breach of contract." *Burton*, 214 F.R.D. at 610. In an action for money damages, each class member is entitled to personal notice and an opportunity to opt out. *Burton*, 214 F.R.D. at 610. Here, the application of this rule to prohibit certification under is even more applicable given Plaintiffs' Motion to Amend the Complaint to seek damages under a variety of other legal theories.

Considering the Plaintiffs' alternative position under Rule 23(b)(3), the Court must find that questions of law or fact common to the members predominate over any questions affecting only individual members, and that a class action is superior to other methods for fair and efficient adjudication of the dispute. *See* Mont. R. Civ. P. 23(b)(3); *Polich*, 116 F.R.D. at 262-263. In determining whether the action fits within Rule 23(b)(3), the rule specifically directs the court to consider the interest of class members in individually controlling the litigation, the status of ongoing litigation brought by members of the class, the desirability of concentrating the litigation in the particular forum, and likely management difficulties. *See*

Mont. R. Civ. P. 23(b)(3)(A)-(D).

The predominance requirement is more demanding than the commonality requirement of Rule 23(a). *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 623 (1997). The predominance test carries with it the implicit requirement that the adjudication of common issues will help achieve judicial economy. *Burton*, 214 F.R.D. at 611. This is determined by weighing the significance of the common issues, not merely by looking at the number of them. *Burton*, 214 F.R.D. at 611 (*relying on Mullen v. Treasure Chest Casino, LLC*, 186 F.3d 620, 627 (5th Cir. 1999)).

In the present case, too many disparate issues exist to support such a finding. There are many separate legal questions, depending on which plans are at issue for a given class member. Likewise, as discussed, factual determinations will predominate. There is no judicial efficiency in certifying a class that will end up requiring separate legal analyses dependent upon numerous factual distinctions. As noted, the mere identification of the actual class as proposed is problematic. In sum, even if the Plaintiffs manage to satisfy the initial criteria for a class action and overcome the other problems inherent in the class definition, common questions of law and fact do not predominate and, hence, a class action is not superior to other methods available.

E. The Merits of the Case

The Plaintiffs' brief protests certain comments by the district court on the merits of the case, arguing it was inappropriate for the court to consider these issues prior to a determination of the class certification motion. *See* Appellants' Br. 30-31. Despite their protestations, Plaintiffs then proceed to spend twenty percent of their brief discussing the made whole doctrine and how they should win the case. *See* Appellants' Br. 30-38. On this issue, the problem with Plaintiffs' case is they seek to apply a doctrine which evolved in the context of "for profit" insurance under Title 33 to benefit programs subsidized by The State for its employees and State-subsidized health care benefits for those who are unable to obtain health coverage through more traditional channels. The rationale which applied to the creation of the "made whole doctrine" in for profit insurance claims simply does not apply in this other context.

Although Plaintiffs refer to "constitutional rights" in support of their theory, outside the confines of workers' compensation cases, the "made whole doctrine" has no constitutional authority, as it is a judge-made law which arose in the context of for profit insurance, as first recognized in *Skauge v. Mountain States Telephone and Telegraph Co.*, 172 Mont. 521,

565 P.2d 628 (1977).[3] Since that time, this Court has specifically acknowledged the made whole doctrine was created by this Court in *Skauge*. *Swanson v. Hartford Ins. Co. of Midwest*, 2002 MT 81, ¶ 15, 309 Mont. 269, 46 P.3d 584 ("In 1977, this Court established the 'made whole' doctrine to be applied in insurance subrogation cases.").

The Plaintiffs' position here is analogous to the arguments presented years ago against another state subsidized program, the Montana Workers' Compensation Uninsured Employers Fund ("UEF"). These claims to apply the made whole doctrine against the UEF were distinguished and rejected by this Court in an opinion authored by Justice Trieweiler, in *Thayer*, ¶¶ 21-24. Recognizing the important distinction between the public purpose of the UEF and other workers' compensation insurance carriers, the Supreme Court stated:

> The Fund is a legislatively provided source from which to minimize the hardships imposed when an injured worker is unable to get workers' compensation benefits as a result of the employer's failure to provide coverage. Furthermore, the statutes which create the Fund specifically provide that claimants to the Fund are not

[3] The Montana Constitution refers to full legal redress for "injury incurred in employment." *See* Mont. Const. art. II, § 16. Also note the *Oberson* case as relied upon by Plaintiffs on this point is a workers' compensation case. *See Oberson v. Federated Mut. Ins. Co.*, 2005 MT 329, 330 Mont. 1, 126 P.3d 459 (Appellants' Br. 31) (workers' compensation insurer's subrogation claim filed against prior tort award).

> guaranteed full payment of benefits provided in the act. *See* § 39-71-510, MCA. We conclude, therefore, that the reasoning on which our prior subrogation cases were based, does not apply to the Uninsured Employers' Fund.
>
> [T]he statutory scheme of the Uninsured Employers' Fund requires that we treat the Fund differently than an insurer. Payments from the Fund are dependent upon the Fund's ability to pay claims. The legislature has directed the Fund to pay claims to the best of its ability and to make proportional reductions to all Fund claimants when the present funds are inadequate to pay all claims. *See* § 39-71-510, MCA. The setoff provisions contained in § 39-71-511, MCA, are uniquely necessary to assure some payment to as many uninsured employees as possible.
>
> * * *
>
> Because the Fund is merely a safety net and stands in the place of the employer, we conclude that it is reasonable to condition the Fund's obligations on the extent to which the employer fails to provide compensation. We decline to extend the analyses of our recent subrogation cases *Ness, Zacher,* and *Skauge* to the setoff applied for the Fund as a result of a recovery from an uninsured employer pursuant to § 39-71-511, MCA. Therefore, we conclude that the Workers' Compensation Court did not err when it found that the Fund properly applied the setoff provision pursuant to § 39-71-511, MCA, to the extent of Thayer's recovery from the uninsured employer.

Thayer, ¶¶ 21-22, 24 (emphasis added). The Court in *Thayer* also concluded that limiting the UEF's obligation did not impair the employee's right to full legal redress against the uninsured employer, nor did the setoff in the UEF violate the right to full legal redress, as set forth in article II, section 16 of

the Montana Constitution. *Thayer*, ¶ 33 (a workers' compensation claimant).

In the present case, The State's employee benefit plan as provided for in Title 2 is analogous to the statutorily created UEF, as discussed in *Thayer*. The purpose of The State's Plan is to provide its employees with adequate health, medical, disability, and life benefits "in an efficient manner and at an affordable cost." *See* Mont. Code Ann. § 2-18-808 (2009). The Department of Administration is designated to oversee the program and maintain it on an actuarially sound basis, reserving sufficient funds to pay claims and liabilities of the employee group benefit plans. *See* Mont. Code Ann. §§ 2-18-809-812 (2009).

This statutorily-created benefit is provided to employees of The State and is also available to their spouse and dependents. Thus, there is a strong public policy to support and continue providing these benefits, just as there is good reason for the legislature to have treated these benefits differently from "for-profit" insurance and, as noted, excluding these benefit plans from the rigors of Title 33. Simply put, The State is not an insurer; but rather, it provides certain health benefits to its employees, their spouses and dependents. These are in part taxpayer dollars that should not go to double-pay medical bills for employees and members of the MCHA plan.

VI. CONCLUSION

The Plaintiffs' have failed to satisfy their burden. They cannot prove the district court abused its discretion denying class certification under Montana Rule of Civil Procedure 23. Accordingly, the district court's order should be affirmed, with the matter remanded for further proceedings.

DATED this 9th day of June, 2010.

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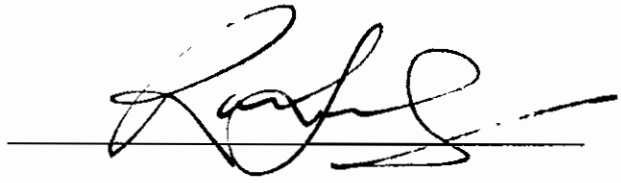
CERTIFICATE OF COMPLIANCE

Pursuant to Montana Rule of Appellate Procedure 11(4)(e), I certify that this Appellee State of Montana's Answer Brief is printed with proportionately spaced Times New Roman text typeface of 14 points; is double-spaced; and the word count, calculated by Microsoft Office Word 2007, is not more than 9,992 words, excluding Certificate of Service and Certificate of Compliance.



CERTIFICATE OF SERVICE

I hereby certify that I served true and accurate copies of the foregoing *Appellee State of Montana's Answer Brief and Appendix* by depositing said copies into the U.S. mail, postage prepaid, addressed to the following:

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